STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120651-001**

Priority Health Insurance Company
Respondent

Issued and entered
this 4TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 19, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner accepted the Petitioner's request for review on April 26, 2011.

The Commissioner notified Priority Health Insurance Company (PHIC) of the external review and requested the information used in making its adverse determination. The Commissioner received PHIC's response on April 22, 2011.

The issue here can be decided by applying the terms of Priority Health Insurance Company's *PPO Insurance Policy*. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

From November 4 through November 13, 2010, Petitioner was treated at the XXXXX. Because the XXXXX is not in PHIC's provider network, PHIC processed the Petitioner's claims using the policy provisions (including deductibles and coinsurance) applicable to non-network providers.

The Petitioner believed that the more favorable in-network provisions should apply in his situation. He appealed the claims processing through PHIC's internal grievance process. PHIC's appeal committee met on March 15, 2011, and affirmed its adverse determination in a letter to Petitioner dated March 17, 2011.

III. ISSUE

Did PHIC properly deny Petitioner's request to process his November 4 through November 13, 2010, hospitalization claims at the in-network benefit level?

IV. ANALYSIS

Petitioner's Argument

In his request for external review, Petitioner and his wife provided a detailed explanation of their argument:

> On October 25th, [Petitioner] started having flu-like symptoms: body aches, severe headaches, chills and a fever. He thought he probably had the flu and kept working until October 29th at which time he went to the doctor. The in-network doctor gave him an antibiotic and a pain shot. On the 30th, he went back to the in-network doctor at the in-network XXXXX and they admitted him and administered blood tests. They could not find what was wrong and determined that he needed more serious care and had him transported by ambulance to the in-network XXXXX. Once at XXXXX, an Internal Medicine doctor was brought in as well as an Infectious Disease specialist and a Hematologist who were all in-network. [Petitioner] had a high fever of 106 degrees and his blood counts were plummeting. The doctors at XXXXX could not find what was causing his illness nor how to treat it. [Petitioner] was at XXXXX for 5 days in declining health including collapsed lungs, inability to walk, catheterization, his white blood cells attacking his bone marrow, red and white blood cells were decreasing at an alarming rate.
>
> By the fifth day, Wednesday, November 3rd, he was admitted to the ICU at XXXXX. On Thursday, November 4th they ventilated him and administered 80% oxygen. The staff at XXXXX felt that the rapidly declining health of [Petitioner] was now at a critical stage and determined he needed the help from the XXXXX for the life saving treatment needed that he could no longer receive at XXXXX. The ICU doctor at XXXXX called Priority Health to pre-certify the helicopter ride to the XXXXX since it was agreed that this was the best route to take. They airlifted him by emergency helicopter to the XXXXX. They opted for this route so that he could be under the direct care of a nurse and a physician due to the health risks associated with traveling while ventilated and on life support.

> Once at the XXXXX, they admitted him to the ICU and he stayed there from November 4-8 at which point his fever broke and he showed improvement although he was heavily medicated and began to have the neuropathy, which has continued. An MRI of [Petitioner's] brain showed a small blood clot behind his eye which was a symptom of his illness. They were able to break it up without issue. He was moved to a regular room on November 8 where he remained until he was discharged on November 13th. The five teams of doctors at the XXXXX still do not have a diagnosis. We have included some of the medical records to confirm the severity of his illness. . . .
>
> We are asking that the out of network charges accrued at the XXXXX be reconsidered as in-network and applied to the in-network deductible and maximum out of pocket accruals. We did everything we could to remain at in-network facilities and the doctor called Priority Health Insurance to pre-certify the air ambulance to XXXXX so obviously Priority Health Insurance knew the destination and approved the transfer. We really don't know what else we could have done to stay in-network.

Respondent's Argument

In its final adverse determination dated March 15, 2011, PHIC wrote that it had "processed the claims to apply Non-Network coverage appropriately in accordance with the Insurance Policy, Schedule of Benefits, and Network Addendum. . . . Claims are processed based on the provider's participation status, regardless of the circumstance."

Commissioner's Review

The Petitioner's policy, referenced in PHIC's final adverse determination, includes this summary of benefits:

Benefits	Network Benefits	Non-Network Benefits
Inpatient Hospital Visits	• 80% coverage • Deductible applies	• 60% Coverage of Reasonable and Customary Charges • Deductible applies

Benefits	Network Benefits	Non-Network Benefits
HOSPITAL SERVICES (Including radiology examinations and laboratory services)		
Inpatient Hospital and Inpatient Longterm Acute Care Services (Including observation care, transplants and maternity stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section)	• 80% Coverage • Deductible applies	• 60% Coverage of Reasonable and Customary Charges • Deductible applies
Benefits	**Network Benefits**	**Non-Network Benefits**
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 80% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies	• 60% Coverage or Reasonable and Customary Charges • High-Tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies

In addition, other policy provisions describe the coverage limitations on medical care received from non-network providers:

> **SECTION 6. Limitations**
>
> To receive Network benefits, you may only receive services from a Network Provider.
>
> **SECTION 8. Claims Provisions**
>
> Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level.

There is no provision in the policy that would require PHIC to provide network level coverage for treatment at a non-network hospital. Also, the policy provides coverage based on the network status of the provider regardless of the circumstances.

The Commissioner finds that PHIC's denial of coverage at the in-network level for Petitioner's November 4 through 13, 2010, hospitalization and related services was consistent with the terms of the policy.

V. ORDER

The Commissioner upholds Priority Health Insurance Company's final adverse determination of March 17, 2011. PHIC is not required to provide coverage at the in-network level for the Petitioner's hospital care provided at the XXXXX during November 4 through 13, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.